471-000-83 Nebraska Medicaid Billing Instructions for Hospital Services

The instructions in this appendix apply when billing Nebraska Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid or enrolled in the Nebraska Health Connection Medicaid managed care plan Primary Care +. Medicaid regulations for hospital services are covered in 471 NAC 10-000.

Claims for services provided to clients enrolled in a Nebraska Medicaid managed care health maintenance organization plan (e.g., Share Advantage) must be submitted to the managed care plan according to the instructions provided by the plan.

NOTE: Billing instructions for the following services are in separate appendices -

- Home health agency services (see 471-000-57);
- Mental health/substance abuse services (see 471-000-64);
- Federally qualified health center services (see 471-000-76);
- Rural health clinic services (see 471-000-77); and
- Nursing facility services (see 471-000-82).
- Hospice services (471-000-81)

For a complete listing of billing instructions for all services, see 471-000-49.

Third Party Resources: Claims for services provided to clients with third party resources (e.g., Medicare, private health/casualty insurance) must be billed to the third party payer according to the payer's instructions. After the payment determination by the third party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the remittance advice, denial, explanation of benefits or other documentation from the third party resource must be submitted with the claim.

For instructions on billing Medicare crossover claims, see 471-000-70. For clients who do not have Medicare Part A coverage or who have exhausted Medicare Part A benefits, all Medicare Part B covered services must be submitted to Medicare prior to billing Medicaid for inpatient hospital services.

Verifying Eligibility: Medicaid eligibility, managed care participation, and third party resources may be verified from –

1. The client's monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

CLAIM FORMATS

Electronic Claims: Hospital services are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Paper Claims: Hospital services are billed to Nebraska Medicaid on Form CMS-1450 (UB-04), "Health Insurance Claim Form." Instructions for completing Form CMS-1450 are in this appendix.

Share of Cost Claims: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the local HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

MEDICAID CLAIM STATUS

The status of Nebraska Medicaid claims can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277). For electronic transaction submission instructions, see 471-000-50.

Providers may also contact Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln) from 8:00 a.m. to 5:00 p.m. Monday through Friday.

CMS-1450 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1450, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Processing
Health and Human Services Finance and Support
P. O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-51 for an example of Form CMS-1450.

Claim Form Completion Instructions: CMS-1450 (UB-04) completion requirements for Nebraska Medicaid are outlined below. The numbers listed correspond to the CMS-1450 form locators (FL) and are identified as required, situational, recommended or not used. See 471-000-78 for a summary of form locator requirements for all services billed on Form CMS-1450.

These instructions must be used with the complete CMS-1450 (UB-04) claim form completion instructions outlined in the National Uniform Billing Committee Data Specifications Manual. The National Uniform Billing Committee Data Specifications Manual is available through the Nebraska Hospital Association. Order information is at: http://www.nhanet.org/data_information/ub04.htm

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
1.	**Provider Name, Address & Telephone Number**	**Required**
2.	**Pay-to Name and Address**	**Situational**
3a.	**Patient Control Number**	**Required**

The patient control number will be reported on the Medicaid Remittance Advice.

3b.	**Medical /Health Record Number**	**Situational**

The number assigned to the patient's medical/health record by the provider.

4.	**Type of Bill**	**Required**
5.	**Federal Tax Number**	**Required**
6.	**Statement Covers Period**	**Required**
7.	**Reserved for Assignment by the NUBC**	**Not Used**
8.	**Patient Name/Identifier**	**Required**

The patient is the person that received services. When billing for services provided to the ineligible mother of an unborn child, enter the name of the mother (see 471 NAC 1-002.02K).

9.	**Patient Address**	**Required**

The patient is the person that received services.

10.	**Patient Birthdate**	**Required**

The patient is the person that received services.

11.	**Patient Sex**	**Required**
12.	**Admission/Start of Care Date**	**Required**

The start date for this episode of care.

13. Admission Hour **Situational**

The code referring to the hour during which a patient was admitted for inpatient care. Required on all inpatient claims.

14. Priority (Type of Visit) **Situational**

A code indicating the priority of this type of visit. Required on all inpatient claims.

15. Source of Referral for Admission or Visit **Required**

A code indicating the source of referral for this admission or visit.

16. Discharge Hour **Situational**

Required on all inpatient claims.

17. Patient Discharge Status **Required**

A code indicating the disposition or discharge status of the patient at the end of the service for the period covered on the claim. Required on inpatient and outpatient claims.

18-28. Condition Codes **Situational**

Use if applicable.

29. Accident State **Situational**

The accident state field contains the two digit state abbreviation where the accident occurred. Required when the services reported on the claim are related to an auto accident.

30. Reserved for National Assignment by the NUBC **Not used**

31-34. Occurrence Codes and Dates **Situational**

A code and associated date defining a significant event relating to the claim that may affect payor processing. Required for traumatic diagnoses. Required on outpatient claims for dialysis, cardiac rehab, electroconvulsive therapy, physical therapy, occupational therapy, and speech pathology. Use other occurrence codes if applicable.

35-36. Occurrence Span Code and Dates **Situational**

A code and the related dates that identify an event that relates to payment of the claim. These codes identify occurrences that happened over a span of time.

37. Reserved for National Assignment by the NUBC **Not Used**

38. Responsible Party Name and Address **Situational**

39-41. Value Codes and Amounts **Situational**

Required on all inpatient claims. Use value code 80 to report covered days, 81 to report non-covered days, 82 to report co-insurance days, and 83 to report lifetime reserve days.

42. Revenue Code **Required**

43. Revenue Description **Required**

When using miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required.

44. HCPCS/Rates/HIPPS Rate Codes **Situational**

Rates are required on inpatient claims for accommodation rooms and on outpatient claims for dialysis services.

HCPCS procedure codes are required on inpatient claims for "other therapeutic services" (revenue codes 940 and 949). HCPCS procedure codes are required on all outpatient claims except pharmacy, supplies and dialysis. Up to four procedure code modifiers may be entered for each procedure code.

HIPPS rate codes are not used.

45. Service Date **Situational**

Required on outpatient claims with date spans (FL6) greater than one calendar day, except dialysis, cardiac rehab, and ambulatory room and board services.

46. Units of Service **Required**

Units must be whole numbers. No decimals or fractions are permitted.

47. Total Charges (by Revenue Code Category) **Required**

Total charges must be greater than zero unless two or more operative procedures during a single session are billed. Only the first procedure requires a charge. Do not submit negative amounts.

48. Non-Covered Charges **Situational**

Enter only Nebraska Medicaid non-covered charges. Do not submit negative amounts.

49. Reserved for National Assignment by the NUBC **Not Used**

50. Payer Name **Situational**

51. Health Plan Identification Number **Situational**

52. Release of Information Certification Indicator **Not Used**

53. Assignment of Benefits Certification Indicator **Not Used**

54. Prior Payments - Payers **Situational**

Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the explanation of Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms.

DO NOT enter previous Medicaid payments, Medicaid copayment amounts, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount).

55. Estimated Amount Due - Payer **Not Used**

56. National Provider Identifier – Billing Provider **Situational**

The unique identification number assigned to the provider submitting the claim. The NPI will be accepted but will not be used.

57. Other Provider Identifier

A unique identification number assigned to the provider by the health plan.
Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12). All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.

58. Insured's Name **Required**

When billing for services provided to the ineligible mother of an eligible unborn child, enter the name of the unborn child as it appears on the Nebraska Medicaid Card or Nebraska Health Connection ID Document.

59. Patient's Relationship to Insured **Required**

Use patient relationship code 18 for all claims.

60. Insured’s Unique Identification **Required**

Enter the Medicaid client's complete eleven-digit identification number (example: 123456789-01). When billing for services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child.

61. (Insured) Group Name **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

62. Insurance Group Number **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

63. Treatment Authorization Code **Situational**

64. Document Control Number (DCN) **Situational**

Required when Type of Bill Frequency Code (FL04) indicates this claim is a replacement claim or void to a previously adjudicated claim.

65. Employer Name of the Insured **Not Used**

66. Diagnosis and Procedure Code Qualifier (ICD Version Indicator) **Not Used**

The qualifier denotes the version of International Classification of Diseases reported

67. Principal Diagnosis Code **Required**

Enter the ICD-9-CM code describing the principle diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). The COMPLETE diagnosis code is required. A complete code may include the third, fourth, and fifth digits, as defined in ICD-9-CM.

67 A-Q. Other Diagnosis Codes--ICD-9-CM **Situational**

Enter the ICD-9-CM codes corresponding to conditions that co-exist at the time of admission, or that develop subsequently, and that affect the treatment received and/or the length of stay.

68. Reserved for National Assignment by the NUBC **Not Used**

69. Admitting Diagnosis **Required**

The admitting diagnosis is required on all claims.

70 a-c. Patient's Reason for Visit **Situational**

71. Prospective Payment System (PPS) Code **Not Used**

72. External Cause of Injury (ECI) Code **Situational**

Required if the principal diagnosis is trauma.

73. Reserved for National Assignment by the NUBC **Not Used**

74. Principal Procedure Code and Date **Situational**

ICD-9-CM surgical procedure code is required on inpatient claims for surgical procedures. The procedure date is required when a code is reported.

ICD-9-CM surgical procedure codes are not allowed on outpatient claims.

74 a-e. Other Procedure Codes and Dates **Situational**

ICD-9-CM surgical procedure code is required on inpatient claims for multiple surgical procedures. The procedure date is required when a code is reported.

ICD-9-CM surgical procedure codes are not allowed on outpatient claims.

75. Reserved for National Assignment by the NUBC **Not Used**

76. Attending Provider Name and Identifiers **Required**

Enter the practitioner's license number. The practitioner license number must begin with the two-digit state abbreviation followed by the state license number (example: NE123456). Enter the attending practitioner's last and first name.

77. Operating Physician Name and Identifiers **Not Used**

78-79. Other Provider Name and Identifiers **Not Used**

80. Remarks Field **Situational**

Use to explain unusual services and to document medical necessity, for example, when unit limitations are exceeded, and for ambulatory room and board services.

81. Code-Code Field **Situational**

To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.